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Original Contributions

A CASE OF INTESTINAL OBSTRUCTION*

M. Blanche Bolton, M.D., San Pedro, Cal.

I was called lately to see Mrs. H. who said she was suffering from one of her usual spells of indigestion and vomiting.

Upon examination I found, pulse rapid, respiration shallow and more frequent than normal; tongue furred and breath foul. The abdomen being more or less distended, motionless and tender upon palpation and percussion, but the only location of constant pain as given by the patient was about the umbilicus. However spells of intensified suffering would intervene, causing severe shock.

There were no stools save the day before when very small quantities of blood and fecal matter had passed. Cathartics and enemas were of no avail and all symptoms were aggravated by any medium which excited peristalsis. Digital examination was made thinking the fecal impaction of the rectum might be found. However such was not the case for upon withdrawal of the finger, a small quantity of blood only was found.

A hypodermic of ¼ gr. of morphia quieted the pain for a few hours.

The next day I found the pulse more rapid, temperature still subnormal, fecal vomiting and increased restlessness. I then diagnosed intestinal obstruction urging an operation as imperative. However the relatives delayed matters by requiring a consultation with an out-of-town physician. We had to wait all day until evening for the physician to arrive. We then found the following additional symptoms:

General peritonitis, listlessness and collapse. The extremities were livid and cold; respiration was hurried and of the thoracic type, pulse rapid, small and weak. After the consultating physician had corroberated my diagnosis a surgeon was employed. When the surgeon arrived next morning matters had progressed too far, and an operation was useless.

Hoping that this paper will bring out a good discussion I simply wish to say in closing that I somewhat condemn myself for not taking matters more in hand and forcing, if possible, an operation without so much delay.

*Read before the Los Angeles County Eclectic Medical Society

DIFFERENTIAL DIAGNOSIS OF APPENDICITIS.

By A. B. YOUNG, M. D., Brownsville, Tenn.

The diagnosis of appendicitis is ordinarily quite simple, when the three cardinal symptoms, viz., abdominal pain, tenderness and rigidity are present, and the number of errors is small compared with the number of cases reported. Still, numerous complications are met with in which the diagnostician is put to his "wit's end" to make a differential diagnosis between the various troubles or diseases simulating appendicitis.

The amount of manipulation necessary to make a complete diagnosis should be of the very smallest possible. Anything more than very light manipulation in one of these cases must be accompanied by a certain amount of danger, because we do not know the thickness of the barrier between the abscess cavity and the peritoneum. The method of leucocytosis or examination of the blood, has been recently suggested as more accurate than the ordinary clinical methods available in making a differential diagnosis in appendicitis. With pus and abscess formation there is an increased number of leucocytes, the increase being proportionate to the amount of pus formation. If there is no leucocytosis the case is either not of appendicitis, or one of the catarrhal form and extremely mild, or very severe and gangrenous, the patient being in a moribund condition.

Hyper-leucocytosis at once differentiates a suppurative appendicitis from simple colitis, typhoid fever, ovarian neuralgia, impaction of feces and floating kidney. By this white blood count pus can be detected within twentyfour hours and an unfavorable prognosis converted into a favorable one, or vice versa.

The majority of errors in diagnosis of inter-abdominal inflammation consists in mistaking atypical forms for other morbid conditions; thus cases regarded as appendicitis have, upon opening the abdomen, proved to be unsuspected pathological processes. A reliable differential diagnosis can be made only by a careful consideration of all the details and symptoms, and as I cannot give all of them here, and a superficial discussion is of comparatively little value, I will have to refer you for the most of the details to the special works or textbooks, on the symptomatology, and shall here limit my remarks to a consideration of only a few of the most important points.

In the very early stages when there is much pain, the following conditions are to be considered, viz.: Renal, intestinal and biliary colic, gastralgia, cystitis, etc. And in woman dissorders of the uterus, adnexa, and pelvic cellular tissue, especially ovarian neuralgia and salpingitis.

Renal colic and cystitis may be differentiated from appendicitis by the absense of the board-like rigidity of the abdominal muscles in the region of the appendix and by the peculiar pain, which is intense and unremitting, being referred to the bladder and genitals. The bladder is very irritable with constant tenesmus and the urine will be found to contain blood, which may be detected microscopically, if not by the naked eye. And as a rule vomiting and fever are absent. We differentiate appendicitis from gall stone colic or chole-cystitis with peritonitis by the pain being higher up in the righ scapular region, passing around to the epigastric region. The pain is of a more severe cutting type in the passage of gall-stones, beginning abruptly, and in many cases jaundice makes its appearance in a very short time. Pains are produced by palpation over the region of the gall-bladder, but there will be little or no pain on pressure or palpation in the right iliac region over the appendix, which marks the difference.

To differentiate between gastralgia, intestional colic or acute indigestion and the beginning of an attack of appendicitis is sometimes a difficult undertaking, as a mild type of appendicitis sometimes very closely simulates acute indigestion with derangement of the stomach and small intestines. But these acute gastric disturbances can usually readily be cleared up by the judicious use of the proper remedies and the non-appearance of the more typical symptoms of appendicitis, makes the diagnosis quite clear.

Acute intestinal obstruction or intussusception may simulate appendicular disease. We must keep in mind that this is a condition which is chiefly met with in childhood; that it comes on abruptly, usually without rise of temperature; there is complete constipation with rectal tenesmus and passage of bloody mucus. If a tumor appears it is not so painful and is quite movable.

A strangulated femoral hernia in a corpulent person might be mistaken for appendicitis, since it is not always easy to make out a small protusion through the femoral ring of an obese person. It must not be forgotten in this connection that coughing does not produce an impulse in strangulated hernia, and there is no rise of temperature, nor tenderness observed over McBurney's point as in appendicitis.

Typhoid fever and appendicitis have been confused and mistaken one for the other. In the beginning of typhoid fever there is usually observed a longer period of malaise with gradual rise of temperature. The patient will bear palpation without much complaint, there being little or no pain in the iliac region. The general picture of a typhoid case differs so greatly from that of

appendicitis that the experienced clinician should have little trouble in distinguishing one from the other. However, in long drawn out cases, without a previous history it is not an easy matter to differentiate between sloughing and perforation in typhoid fever and that of a gangrenous and perforating appendicitis.

To diagnose a case of appendicitis when the appendix is abnormally long, or when it is displaced together with the caecum, may be very difficult, or even impossible. In such cases a true peri-appendicular inflammation and swelling may be taken for a perinephritic, or for gall-bladder trouble. Or, again, the tumor may be found in the region of the umbilicus, or even as has been recorded in the left iliac fossa, and in the pelvis. In such cases, particularly when the previous history is obscure, the diagnosis becomes very difficult, or even impossible, without making an exploratory incision into the abdominal and peritoneal cavities.

In women diagnosis must be made between appendicitis and diseases of the uterus and right adnexa, including tubo-ovarian diseases, tumors, salpingitis, etc. To make a differential diagnosis in these cases will frequently be found a difficult matter to accomplish. Examination of the gento-urinary organs will sometimes establish a differential diagnosis, the hymen being intact and by bimanual examination one can usually determine whether the inflammation or induration and tumefaction is in the pelvis and connected to, or in relation with the uterus.

Inflammation of the right tube and ovary and of the appendix may occur at the same time, and we have in both, rapid pulse, rise of temperature, pain, vomiting, and tympanitis. In such cases the diagnosis may be very difficult. However, appendicitis begins more acutely, the pains being more violent, with marked rigidity of the abdominal muscles, or, if it be a chronic case, there is a history of one or more former, sharp and sudden attacks. Lesions of the tubes and ovaries are usually of older date, and have a history of menstrual disorder, the pains are dull and heavy, and not so lancinating until the peritoneum becomes involved. Vomiting is more common in appendicitis, and rigidity of the abdominal muscles over the right iliac region is almost always present. These constitute the principle differential signs between acute appendicitis and salpingitis. Also between appendicitis and various other troubles and diseases of the uterus and the right adnexa. Judgment should not be too hastily passed on tumors in the right iliac or caecal region, for mistakes are frequently made by physicians and surgeons of distinction.

And an operation or opening of the abdominal cavity becomes necessary to clear up the diagnosis, as in the case of a little ight-year-old girl, which recently came under my observation.

The child had had several attacks of what was supposed to be recurrent appendicitis. The last attack occuring in January last, when several physicians were called into consultation, all of whom pronounced it appendicitis, and as the ordinary therapeutic treatment proved of little effect, an operation was advised.

The patient was taken to Nashville and placed in the hands of a distinguished surgeon, who concurred in the former diagnosis. But upon operation an ovarian tumor of considerable size filled with a cartilagenous substance and a tuft of hair was revealed, which the operating surgeon said was caused by a double conception, and instead of twins being formed in the mother's womb, by some pecuilar freak of nature, the child's ovary became affected, making this one of the rarest cases on record. The operation was a success, and the patient made a rapid and complete recovery.—(Transactions of the National Eclectic Medical Association).

THE X-RAY DIAGNOSIS AND TREATMENT OF FRACTURES.

By A. O. Conrad, M. D., Prof. Orthopedic & Clinical Surgery, California Eclectic Medical College.

A fracture is a solution in the continuity of bone, the same as a wound is a solution in the continuity of tissues in general.

The diagnosis of a fracture is at times quite easily made and and again may tax the skill and ingenuity of the most successful surgeon, and even after a most careful diagnosis by manipulation, comparison, etc., even under anaesthesia, fractures have been replaced in what was considered the correct position, and perhaps a very positive, affirmative prognosis, as to a perfect result, given, when a few weeks later to the surprise and chagrin of the surgeon, upon removing the dressings, there would be either complete loss of mobility in what seemed a trivial fracture near a joint, or else non-union in what may have appeared a simple uncomplicated fracture.

Again, after a most guarded prognosis and a great deal of anxiety on the part of the surgeon regarding what he was positive was a very complicated fracture, and in which he was very apprehensive of the results, would, to the surprise of all, have perfect union and perfect function.

There is a reason for the difference of results in cases so different in their manifestations and which can only be ascribed to an error of diagnosis.

The diagnosis then of fracture becomes a necessity of first importance and presents some difficulties that before the advent of the X-Ray, were well nigh impossible to overcome and even with it at present sometimes difficulties that only one thoroughly versed not only in X-Ray technique, but also in the interpretation of the shadows cast upon the flourescent screen or impressed upon the radiographic plate, can decide, and even here the gravest errors have been made by misinterpreting the appearances of the bones, with their relationship to each other at different periods of life, as before ossification of the various portions, etc.

Apparent epiphereal separations, normal in children, have been diagnosed as fracture, while a real fracture was overlooked perhaps by making the common error of not examining the part in different positions, as for instance, a fracture of the olecranon, while very clearly defined when viewed laterally, may be difficult or impossible to detect when viewed antero-posteriorly.

The same may be said of Colles fracture when the direction of the line runs in a slanting direction from the anterior to the posterior portion of the bone. Here an ant-post-view, especially by an inexperienced observer may seem normal, when a lateral view would show great displacement.

The surgeon, who would employ the X-Ray as an aid in making a clear diagnosis, must first of all familiarize himself with the normal appearance of the various osseous structures, as their density, as well as their relative positions, are so different at various periods of life, for instance, in children, take the elbow-joint, and we find that the osseous nucleus of the interior of the Capitulum Humeri appears between the second and third year, another nucleus shows in the internal Epicondyle at the fifth year, a third in the Troclea between the eleventh and twelfth year, and soon after, another in the external Epicondyle.

The nucleus of the internal Epicondyle unites with the Diaphysis between the sixteenth and twentieth year; but the other three nuclei form a synotosis among themselves at the seventeenth year, then constructing the uniform osseous Epiphysis which completes its synostosis at about the twentieth year.

In very young children, the Eminentia Capita appears as if entirely separated from the Humerus, although its relations are normal. This is easily explained by the fact that the epiphyseal tissues are not sufficiently ossified to produce a shadow on either the screen or the plate.

Again, we find that the lower Epiphysis of the Humerus consists of four neuclei, which do not ossify until from the eighth

to the seventeenth year. The fractures of childhood are also influenced by disease, as Rachitis, which sometimes delays ossification.

We have but to consider a few of these physiological facts to see at once the great difficulties in diagnosing fractures; for errors can be made by mistaking a normal point of ossification for a detached fragment. Such a case recently was the basis of a suit for damages. The patient, a lad of ten, fractured the external Epicondyle, which the radiograph plainly showed. Callous formation prevented full movement of the elbow-joint and the parents being dissatisfied, called on Dr. X., a surgeon, who had another radiograph taken, which when produced showed the Epicondyle in normal position, but apparently loose, as ossification as mentioned before, does not occur before the seventeenth year.

The radiograph, not having been accurately centered with relation to the focus tube, produced an exaggerated position and an apparent displacement. The surgeon diagnosed the case as one of fracture of the Capitellum, by mistaking the shadow of the normal Epicondyle as that of the Capitellum displaced and united in a false position. He subsequently operated and removed the normal Capitellum, relying upon the falsely interpreted radiograph, instead of upon his surgical skill and the result of the operation was a so-called flail joint.

The surgeons who first attended the injury, were sued for mal-practice and only by production of a number of radiographs of normal elbow structures, could the jury finally be convinced of the error of the operating surgeon and the suit was therefore dismissed.

Another source of trouble as intimated earlier in this article, is the position in which the limb is placed when the skiograph is taken, for illustration; place your two index fingers, side by side, upon a photographic plate, expose the same to the action of a tube and upon developing the negative, you will find that two fingers side by side are shown. Now place one finger above the other and make another exposure and you will find that the result will look like one finger, as the superimposed images are hard to distinguish and appear really as one object.

A case in practice will illustrate this point and show its importance. Mr. C., 25 years of age, had a heavy iron weight fall across the Femur, with a resulting fracture. He was removed to a hospital where the house surgeon set the limb, but after four weeks immobilization and extension, was surprised to find that there was non-union. He at once, upon discovering this, made an ant-post. radiograph and was surprised to find that this

showed an apparently good reduction and was extremely puzzled by the non-union.

Upon being called in consultation and viewing the radiograph he had taken, it was at once apparent to me that he should also have taken one laterally, which I now proceeded to do and when developed, it showed a displacement between the fractured surface of one-half inch. It also showed that extension had not been carried far enough to pull the fragments into correct apposition. In this case the operation of wiring was resorted to with a perfect result.

In skiographing the bones of the skull, face, spine and ribs, we have a great many difficulties to overcome, as here we always have bones superimposed upon one another and only a most careful and painstaking examination of the radiograph can detect the fracture.

As regards perfect reposition, the X-Ray has in old fracture cases shown how the most competent surgeons sometimes make very grave mistakes. Carl Beck, Surgeon to New York Post-Graduate School, gives a number of very interesting cases that came under his notice, one being a fractured fibula, skiagraphed after being set by a very prominent surgeon, and assumed to be correct. The skiagraph showed the fragments actually over-lapping. Another case he mentions, is one in which he himself was unable, in an injured elbow, to detect any marked symptoms of fracture, except at the external condyle, but the skiagraph revealed the presence of a fracture of the head of the radius associated with considerable displacement, infraction of the external and fracture of the internal epicondyle, the latter without displacement.

Since he could so easily locate the displaced radial fragment, he thought that he could also succeed in easily reducing it, but neither he nor any one of a number of other surgeons were able to palpate it. The position of the fragment was marked and pressed inward, (being displaced outward). A fenestrated plaster of paris dressing applied and a radiograph taken which impolitely showed the condition worse than before. After four attempts at reduction, with the arm extended, he succeeded in replacing it.

This brings to light also another point of great value, viz., the necessity of operative interference, for when reposition is shown to be impossible, it at once also shows operative treatment to be imperative and further, will prove if after operative procedure there is a perfectly satisfactory result.

In some fractures we are unfortunate enough to have as a complication, a separation of the fragments by the intervention of muscle tendon, cartilege, etc., (diastasis). Here again the X-

Ray gives the only proof as to whether or not, the parts can or cannot be brought into apposition and retained there.

After a fracture has had the proper dressings applied for the required time, we are often much concerned by what seems an abnormal amount of fixation and here again, the use of the flouroscope will help diagnose the trouble. It may be that the fragments became displaced subsequent to their reduction, a callous may extend in such direction as to interfere with the proper function of the joint, or it may be due simply to prolonged fixation and simply require passive motion for its connection.

And last, but not least, the medico-legal side of the question is most interesting, especially if you have had the intense pleasure of being sued for damages for mal-practice. Here a radiograph taken before and one taken subsequent to the reposition, will be one of the greatest factors in your defense; only be sure the radiograph is marked in such manner that you have proof of correct technique in placing the lesion correctly with regard to the angle of the rays.

You must be able in court to prove that the radiograph is free from distortion, or else be able to show the exact amount of distortion present, which will carry more weight if the party claiming damages happens to present a radiagraph which lacked evidence of correct exposure, and which likely as not, has been purposely so placed, in order that it will show the greatest amount of distortion, which would make a trifling lesion, or even a normal joint appear greatly out of proportion and so strengthen their case.

The author recently had such an experience in which it was necessary to satisfy the court and jury of the correctness of a skiagraph he had taken, to take one of a normal join in both the positions in which the one claimed to be correct, had been postured, and then one in the position in which it would have to be placed, in order to produce the result shown in the one presented by the prosecution.

It is unnecessary to state that such evidence of correct technique would go a long way in establishing the fact that due diligence and a reasonable amount of care had been showed by the defendant.

In subsequent articles, diagnosis and treatment of the various individual types of fractures will be discussed.

An easy means of holding a small scalp dressing in place consists in tying over it strands of the patient's hair.—American Journal of Surgery.

A CASE IN PRACTICE.

F. G. DE STONE, M.D., San Francisco, Cal.

August 15th, about ten o'clock I responded to a "hurry up" call and was ushered into a small bedroom where lay a young English woman of about thirty years of age; the females of the family were weeping loudly and the man in the case seemed distracted and as soon as I entered, grabbed me by the arm and almost hissed at me, "Aw docter, but this is a rum go, don't cher know, but you must do something that quick."

I found the woman had taken a teaspoonful of chloroform and she now lay on the bed in rigors similar to those of strychnine poisoning, she shook so hard that the bed shook with her. Her heart beat so fast I could not count it, and death seemed imminent.

I ordered them to give her a teaspoonful of sodium bicarbonate in a glass of water while I got a hypo ready of morph., 1-8, strych., 1-50 and Apomorph., 1-10 and shot it into her. I do not know whether that was a scientific stab or not, it was all I had with me, and this was the first case of the kind I ever saw, but as it won out I have the best of the man who says it was a "Rum go."

For a time the rigors increased, she became stupid for a few minutes and then threw her arms in the air as I shook her, and let out a yell for a basin and the way she rolled out soda and Tait's French dinner made the Englishman's eyes bulge out.

The turn in affairs relieved me almost as much as it did the woman for I do not know what I should have done had she not helped me out.

In about half an hour the heart became somewhat normal, the shaking ceased and aside from fits of uncontrollable laughter she was all right.

A visit the following morning found her all right save a little "jagginess."

SHOULD A DOCTOR DISPENSE HIS OWN MEDICINE?

THEODORE JUDSON HIGGINS, M. D.

The doctor who dispenses his own medicines has more than once been the personality attacked by a certain class of druggists and just at this time we find that history is repeating itself. Certain individuals both of the American Pharmaceutical Association and of the National Association of Retail Druggists are doing all in their power to secure legislation, to have prohibitory measures passed to make it unlawful for physicians to dispense their own medicines. To analyse some of the paragraphs ap-

pearing in the editorials of the more rabid Pharmaceutical publications one might be led to think that all knowledge of medicine might be found only to exist amongst the profession of Pharmacy, and that circumstances surrounding them now were not very much better than they were several centuries ago, when apothecaries prescribed their own remedies on their own responsibility, without the countenance of a member of the medical profession. During this period if a pharmacist was even threatened with censure or any other punishment by a licensed physician they retorted by discontinuing to call him in consultation and by using their influence to ruin him in every way possible. Of course jealousies and hatred soon sprang into being. Naturally starving graduates in medicine with diplomas from great colleges such as Oxford and Cambridge would assuredly become embittered if for nothing else than the fact that they were compelled to tramp the steets with their diplomas in their pockets. Especially when they saw the mean mixers of potions and pills (who had scarce scholarship enough to construct a Latin prescription) dashing by in their carriages. Of course the natural out-come of these heartaches was a paper warfare, as rancorous and disgraceful as any disagreement ever prescribed in literature. The scientists and students called the rich tradesmen thieves, swidlers (the use of the word grafter was not appreciated) and unlettered disreputable block-heads. The rich tradesman taunted the scholars with discontent, falsehood and of ignorance of everything practicable except Latin and Greek. Of course the majority of enlightened people took sides with the educated physicians. In the protracted dissensions between the physicians and the apothecaries Pope was a cordial supporter of the physicians. For instance in his Essay on Criticism he accuses the penny-a-liner critics of acquiring their smattering of learning of poetic art from the poets they assailed. He compared them to apothecaries whose information was pilfered from the prescriptions they were required to dispense. We will quote: "Then Criticism, the Muse's hand maid proceeded to dress her charms and make her more beloved; But following wits from that intention strayed; Who could not win the mistress, wooed the maid; Against the poets their own arms they turned, Sure to hate most the men from whom they learned. So modern 'Pothecaries taught the art, by doctor's bills to play the doctor's part, Bold in the practice of mistaken rules, Prescribe, apply and call their masters fools."

Circumstances are much different now than then. Both the true physician and the true pharmacist are much better qualified now than they were then. It would seem to us that they

should be more liberal. It is simply ridiculous that in the 20th century there should be so much jealousy, envy and hatred between and amongst the professions. It is only fair to assume that the physician at the bedside is qualified to dispense his own medicines or at his office for chronic cases as he thinks indicated. The right to furnish medicine to his patients is as natural to the physician as the use of a saw is to a carpenter. The physician should have a true knowledge of Pharmacology and of the chemistry of medicine and if he so desire a practical knowledge of the art of pharmacy. One might truly say that the carpenter must not saw a board or drive a nail just because he does not understand the art of making saw steel and the general working of metal, and yet would not the average metal worker make a fizzle of constructing a house? Yes, just about as good an example as the average druggist makes by counter prescribing and by trying to prevent the physician dispensing the medicine made by his art. Gentlemen, let us exercise a little common sense. It is hardly probable that the efforts at present being put forth by this galaxy of individuals (for we can hardly believe that the majority of intelligent pharmacists are parties in any sense of the word to this infamous proceeding) will amount to anything of importance, still it *behooves* every intelligent physician to be alert and to use his influence to prevent any such unjust legislation. An editorial which appeared in a recent issue of the Western Druggist commenting on an article by B. L. Maltbie in the Medical World serves to illustrate the position taken by certain people who claim to represent American intelligence; "If by a statement that the majority of physicians are *oblidged* through force of circumstances to dispense, (the doctor refers to emergency or bedside dispensing) no one is disposed to dispute it and no one has any objection to this necessary dispensing. In fact, the right of the physician is so axiomatic that it needs no demonstration and has never been disputed." Now as a dispensing physician I would contend that if we have the right to dispense in emergency or desperate cases we certainly possess the right to dispense for the less acute and less dangerously ill, for as all physicians and surgeons know, the greatest degree of learning and skill is called forth in desperate cases. This same editorial insults the dispensing doctors by making the following assertion: "The proportion of incompetent druggists is no greater, and probably not nearly so great, than the proportion of incompetent physicians. It is usually the less competent physicians who practice dispensing. The dispensing physician is constantly giving the next best thing, when the drug he knows he should have is not in his necessarily small stock." So much for the Western Drug-

gist. In comment let us say doubtless the *editor's judgement is an honest one.* He knows what he would do provided he had the chance, and consequently he adjudges others accordingly. We are dispensing physicians and surgeons and we find it very conveient to carry a full line of remedies for our practice. We have no quarrel with our brothers in the Pharmaceutical profession and at any time on special lines which we carry we are very much pleased to work in harmony with our local pharmacist and to supply them often times from our stock and we believe that they are our friends and that we possess many friends in the pharmaceutical profession throughout America. We therefore most seriously resent these remarks against the medical profession as a whole believing that the true physician and the true pharmacist are working harmoniously throughout these United States and the world at large.

We have no quarrel with the druggists, but remember the physician's business is of such a nature that he must be unhampered and free to act and to do whatever he deems best for his patient's best interest. Now we wish to reiterate; We, *the writers of these papers are dispensing physicians and proud that we* are and we suggest, doctors, that you keep your eyes and ears open, use your influence to prevent any legislation toward *forcing* you to use a *prescription pad* for any of your patients who require medicine. By all means dispense your own medicines. Squeeze the water out of every fad, learn to estimate the true value of every remedy and then like the experienced ax man you can learn to hew exactly to the line. This is the truth of the matter as we see it. Having spent the cream of our life in the study of these subjects and as an experienced and practical pharmacist as well as physician and surgeon we feel that unless a doctor does understand the chemistry of medicine he has no earthly business to prescribe a combination; on the other hand, knowing his pharmacology and the results to be expected he certainly possesses the right to prescribe and to dispense as well, whenever and wherever he sees fit to do.

WATER IN PEDIATRICS.

John M. Fearn, M.D., Oakland, Cal.

What a wonderful boon to man is pure water. 'Tis a boon to the sick and to the well, to the young, and to the old.

By long observation I come to the conclusion, that water is not used among the sick as much as it should be; especially amongst infants.

Let me illustrate. Many years ago I was called to administer to a child in the night. As I stood by the bedside how it

did cry. I watched it closely for a little while, and soon came to the conclusion that its cry was not from pain, but from want. And that want was water. I fed cold water to it, and how eagerly it drank it down, and when it had received sufficient, it fell into a sound, refreshing sleep.

My diagnosis was specific. And my remedy was specific. I never forgot it. I say let the child have plenty of water. What does it do? It soothes and cools the gums and the inflamed glands in the buccal cavity. It cleanses the stomach, it increases the action of skin, kidneys and bowels. And by all these means it lessens fever. This water may be plain or it may be medicated by alkalies or acids, etc. Then think of its value in flushing the bowels. Surely no doctor who has ever seen it used would think of treating bad cases of colic, cholera infantum, typhoid fever, dysentery, fecculent diarrhoea, etc., etc., without using bowel lavement. A few weeks ago I was called to see an infant four weeks old. I was informed it had cried almost ever since it was born. I came to the conclusion that it was a case of severe colic, largely due to artificial feeding, the mother's milk having been dried up. The colic had continued so long that the bowels and stomach were very tender. Attention to food and giving simple remedies did a great deal. One teaspoonful of tincture of asafoetida added to warm water half a pint was slowly passed into the bowels. It soon came back with considerable discharge of gas, and the child was much relieved. Then think of the local application of water, either hot or cold as the physician shall indicate, by packs: To the abdomen in enteritis and gastritis; to the chest in pneumonia and pleurisy; to the throat in laryngitis and tonsilitis; over the bladder in cystitis; and also to the joints in arthritis. In using these packs be sure that they are properly applied. See that the wet flannel is properly covered up by the oil silk and over all dry pads; in this way the moisture and heat are kept in, and the bed clothes are kept perfectly dry. In cases of very severe sciatica, few procedures will bring such relief to the sufferers as a well-applied pack, medicated as specific conditions may indicate.

In fevers with very high temperature a good blanket or wet sheet pack, enclosing the patient from head to foot, will do more for the patient's comfort, will bring down temperature quicker and will do it more safely and much quicker, than any coal-tar preparation ever made. And, in my opinion, it is far better than the old fashioned steam or vapor bath, and this is saying much, for this writer has seen those procedures do wonders for the sick, breaking up fevers and con-

gestions, and restoring very sick people to a normal condition in a surprisingly short time.

Now what shall be said about foot baths, sitz baths, and full baths in diseases of childhood? I say their effects are simply marvelous. No one who has not witnessed their effects can have the faintest idea of the therapeutic worth of these procedures.

Let me close with one illustration. Over thirty years ago I was called to see a little boy very sick with scarlet fever. It was a home of comfort and plenty. But it was their only child and they feared he would be lost as so many others had in that neighborhood, for the disease had been very fatal. Temperature was very high, the skin hot and dry, the brain surcharged with blood, the eyes bright and staring and the boy almost worn out from lack of sleep. How anxiously those parents waited for the doctor's prognosis. Was there any hope? I told them if they would give the boy a hot bath as I would suggest, he might be saved. But they durst not take the responsibility of putting him in a bath. They begged me to stay and see to giving the bath. A very large milk can, such as were used to carry milk to the cheese factory, was brought into requisition, the boy was placed therein and water as warm as could be comfortably borne was poured in until it came up over his shoulders. Then a turban was made of several thicknesses of flannel; this was placed on his head. Then I took a big jug of cold water and very slowly poured this over the turban till every part was thoroughly wet. The head soon became cool, the eyes less bright and staring, the skin softened up. He was lifted from the water, rolled in a blanket and put into bed. In a few minutes he was in a refreshing sleep, and after a long sleep he woke up, the fever abated. The crisis was passed, he was safe, and those people said they had never seen anything like it. And I am of the opinion that there is no medicine known to physicians that could do such work in so short a time, as that simple application of hot and cold water.

Moral: In Pediatrics never forget water inside and out. I used to tell my class in the California Medical College, that if in my practice I had to give up either medicine or water, sticking to one only, I would give up medicine and keep to water. (Transactions of the National Eclectic Medical Association.)

Transverse scalp wounds require comparatively many sutures, longitudinal wounds but few.—American Journal of Surgery.

THE CALIFORNIA ECLECTIC MEDICAL JOURNAL

The Official Organ of the Eclectic Medical Society of the State of California, the California Eclectic Medical College, the Southern California Eclectic Medical Association, the Los Angeles County Eclectic Medical Society and the Los Angeles Eclectic Policlinic.

Contributions, Exchanges, Books for Review and all other communications should be addressed to THE CALIFORNIA ECLECTIC MEDICAL JOURNAL, 818 Security Building, Los Angeles, California. Original Articles of interest to the profession are solicited. All rejected manuscripts will be returned to writers. No anonymous letters or discourteous communications will be printed. The editor is not responsible for the views of contributors.

MILK DIET.

As an article of diet, milk is universally used by those people who are commonly designated as pastorals. While goats, sheep, camels and mares are pressed into service to furnish man with his so-called "food from nature," yet it is of the docile cow that most of us think when the source of the milk supply is discussed. As above suggested, the drinking of milk belongs to a stage of civilization which if not inferior, at least preceded that of our own. To rob the young of other animals was an easy way to obtain nourishment, and they did it. It has been said that man became a milk drinker because of the habit developed in his extreme youth; but this we doubt, having never been able to find a man who has a distinct recollection of ever indulging in his mother's milk, let alone remembering the flavor thereof. Our ancestors originally drank milk because they were hungry and it was easy to get. Our children drink milk because they are hungry and it is placed before them. We do not drink milk today because of any sentiment, nor do many people, especially like its flavor. We use it because our ancestors did; and because there is an unshakeable belief that it is wonderfully nourishing. With most people milk is "the nature's food," and to most people any "nature's food" is a kind of fetish. A contrary suggestion is a kind of sacrilege, and a contrary argument falls upon deaf ears. The majority of the American people are

milk faddists when they are well, the remaining minority are milk cranks when they are sick. If a patient has an indigestion and is unable to eat pork, cornbread, cabbage and pickles; then he thinks of nothing but milk, milk, milk, and the doctor is forced to consider the same threadbare argument of nature's food, just as though the idea had never occured to him before.

The argument is usually presented about like this: The healthy new-born calf gets warm milk in driblets from its mother's udder and waxes exceedingly strong; therefore all that is necessary for a man to do who has a broken down alimentary tract, is to gulp down a glass of ice-cold milk, and presto! he is strong again. Such a patient is hard to manage. You try to teach him that human milk is quite dissimilar to cow's milk, but he replies that he drank it when he was a boy and is still alive. Possibly you will suggest that he also ate raw potatoes, green fruit and mud with equal gusto, and as these are "nature's foods," they are in order also. Then you show him that to be measurably consistent he must take his milk through a very small straw and blood warm direct from the cow; but he doesn't relish warm milk. However he still insists that he is a "back to nature man" and must have nature's food, so there is nothing the poor doctor can consistently do but to get the patient a wet nurse and leave nature to effect the cure.

It is our belief that the use of milk kills many times as many people as any other article of food. And at the same time we wish to state that we have no patience with the assumption that the milk in a cow's udder contains baccilli tuberculosis or any micro-organism whatever. But there is no doubt but that as furnished to the consumer milk is contaminated with all kinds of bacteria and in numbers almost beyond belief. The difficulties of procuring a quart of milk uncontaminated, and keeping it so until served to the consumer, are almost as great as those met in performing a clean abdominal operation. There is this striking difference however, that in the latter the patient recognizes that his life is at stake and he is willing to pay a considerable sum of money to carry out the necessary technic; but in the former he does not recognize that his life is at stake and he haggles at 8c. In other words while it is theoretically possible to deliver pure milk to the consumer, practically it is not worth the cost of production. Therefore with the knowledge that milk contains all kinds of bacteria, as well as manure, flies, sweat and tobacco juice, what do we do to it? Most people sterilize it. This procedure is designed to kill the bacteria, and we try to forget about the etcetera. Of course by sterilizing milk it is changed as to its original constituents and it certainly is no longer a "nature food," but we forget that part also.

Milk as found in the cities is the filthiest and most dangerous article of food at present served to the human race. It might truthfully be said of it "Eat, drink and be merry for tomorrow you die."

NEW MEDICAL LAW TO BE SOUGHT FOR STATE.

That the agitation about the State Board of Medical Examiners for alleged discriminations in the conduct of examinations, will result in action farther reaching than the mere investigation of the charges, is evidenced by the fact that a draft of a new law already has been made, providing for the reorganization of the State Board on entirely new lines.

The proposed law, prepared under the direction of a Los Angeles attorney, will be presented to the next session of the legislature.

It is designed to eliminate most of the alleged abuses of the present law and institutes radical changes.

It provides, first, that the appointment of members of the State Board shall not be made, as at present, upon recommendations of medical societies and associations in the State but shall be made by independent selection.

This change is designated to bring the State Board from under the control of the organized medical societies, which it is alleged, have used their powers in the matter of recommendations to the State Board to form a close monopoly in the matter of distribution of medical licenses.

As another change, the new law will make a regular provision for the review of examination papers, in cases such as the present agitation, where applicants complain that they have been treated unfairly.

Provision also will be made for the granting of licenses to physicians from outside states, who can present approved credentials of graduation from colleges of recognized merit and can show a certain number of years of active practise.

Another section will provide that students graduated from approved medical schools in the State of California shall be admitted upon motion, just as is done now in admitting law school graduates to practise.

Other minor reforms are aimed at.—*Los Angeles Express.*

DOCTOR VERSUS QUACK.

Did it ever come to your mind that our long, great, valiant fight for medical registration, state board of examination, four year courses, for medical organization and dignity, has ended in

utter failure? We are just where we began twenty years ago. Then the Sick Citizen had a choice between quacks and regular practioners and the law could not be invoked to protect the citizen from greed and ignorance. How is it now? The law now demands the legalization of osteopathists and eddyites and Albany (not heaven) only knows what other forms of Healers and healers. Progress is giving the former unlegal and despised quack a legal and professional status. Isn't that an atrociously funny result of the generation—long demand for professional exclusiveless and registration? But only sillies can fail to see that it is leading to the right of the citizen to choose his doctor, or his quack, or his murderer as he pleases. And nothing on earth or heaven can prevent this democracy.—*George M. Gould.*

THE TRAINED NURSE OF TODAY.

In the Mobile Medical and Surgical Journal, July 1908, is an article describing the trained nurse of two decades ago and describing her evolution down to the present day and enumerating her faults. The article is interesting and well written yet would it not be better to draw the mantle of charity over her faults, and remember only her good qualities? Let us remove the beam from our own eye ere we seek the mote in our sister's eye.

My experience is that the trained nurse is the physician's best friend and if the nurse was better treated by some physicians, she (being human) might feel inclined to look after the doctor's interests more closely. The physician and nurse should work together in perfect harmony and assist each other. It is just as much the doctor's duty to look after the welfare of the nurse as it is the duty of the nurse to protect and promote the doctor's interests.

The nurse who does private work, nursing in the homes and especially in country homes, is often imposed upon by the family and neglected by the doctor. This is not from malice or done intentionally. It is simply thoughtlessness. When the nurse comes and takes charge of the case the doctor gives instruction as to giving medicines, etc., gets in his buggy and drives away feeling sure his patient will have good attention, that his instructions will be followed to the letter, and the nurse assumes all responsibility except the prescribing of remedies. The family turn over to the nurse the nursing of the case, the care of the room, the preparation of the patient's meals, the removal of slops from the sick room, and in fact all work and care in any way caused by the patient.

The nurse is busy all day giving medicine, preparing meals, bathing and massaging the patient and doing the thousand and

one little things, no one of which amounts to much but all of which help to make the patient comfortable and make him satisfied that he has the best doctor in the world. All night she must give medicines every one, two or three hours, and is called on many times to give some little attention to the patient. Sometimes she works like a trooper all night, and this is not only for one night but every night throughout the illness, and if it be a protracted case the nurse is worn out ere it is ended.

Doctor, how would you like those hours and amount of work? I have always tried to look after the interests of my nurse. I call the attention of the head of the family or the one in charge to the work the nurse is doing and to the little rest she gets, and demand that some one be provided who can look after the patient while the nurse gets enough rest and sleep to maintain her own health if it be a protracted case. I also demand that the nurse have not less than an hour in the open air each day. The nurse will appreciate this. The family of the patient will see that it is reasonable and not object, and the quality of the nurse's work will convince the doctor that a charitable deed is never thrown away. I also try to impress on the minds of housekeepers that it is not the duty of a trained nurse to do any of the house-keeping or cooking except in the preparation of special dishes for the patient.

Doctor, don't forget to look out for your nurse's welfare and you will have no cause to complain of "the way trained nurses treat physicians."

DISPENSING OF POISONS.

Much has been written on this subject, yet we can never sound the note of warning too often, especially to those whose experience with the handling of active poisons has been limited. The possible danger of carelessly handling and having vials containing active poisons mixed with other vials containing drugs is great, no matter who handles them, for no one is infallible.

The writer, only a few days ago, had the painful experience to administer antidotes to a young physician who had taken fifteen grains of bichloride of mercury, tablet form, in a mistake for lithium tablets.

He being of a rheumatic diathesis and his kidneys being somewhat inactive, he was in the habit of taking two lithium tablets in a glass of water before retiring. During the day he had bought at the drug store bichloride tablets which were dispensed in a vial which was almost identical with the vial containing the lithium tablets. He placed the vial containing the bichloride on the same sheft with the lithium vial, and that even-

ing he dissolved two bichloride tablets in a glass of water, thinking he had the lithium, without reading the label, and did not discover his error until he had all the solution in his stomach.

This was, of course, a bad and painful mistake on the part of the doctor, but had the bichloride been dispensed in a special "poison bottle," he would at once have discovered his error as soon as he touched the bottle. *All* poisons should be dispensed in rough and colored bottles so that they could be distinguished readily at night by the touch of the hand.

It is true that every one should always read the label before taking any medicine, but why not have double precaution when no expense or even energy is required to give us such protection.

It would also be better to have all bichloride solutions and tablets colored with methylene blue, which has no influence on the antiseptic and germicidal properties of the mercury.

—*Monthly Cyclopedia and Medical Bulletin.*

SOCIETY CALENDAR.

National Eclectic Medical Association meets in Chicago, Ill., June, 1909. J. K. Scudder, M.D., Cincinnati, Ohio, President; W. P. Best, M.D., Indianapolis, Ind., Secretary.

Eclectic Medical Society of the State of California, meets May, 1909. J. A. Munk, M. D., Los Angeles, Cal. President; J. Park Dougall, M. D., Douglas Bldg., Los Angeles, Secretary.

Southern California Eclectic Medical Association meets in Los Angeles in May, 1909, E. R. Harvey, M.D., Long Beach, President; A. P. Baird, M.D., Auditorium Bldg., Los Angeles, Secretary.

Los Angeles County Eclectic Medical Society meets at 8 p.m. on the first Tuesday of each month. Dr. M. Blanche Bolton, San Pedro, Cal., President; Dr. P. M. Welbourn, 818 Security Building, Los Angeles, Secretary.

COMMITTEE ON MEDICAL LEGISLATION

In view of possible new medical legislation next winter at Sacramento it has been deemed advisable to appoint a Legislative Committee from the Eclectic Medical Society of the State of California, to conserve Eclectic interests in the legislature as follows: Dr. L. A. Perce, Long Beach, chairman; Dr. J. C. Mitchell, San Francisco; Dr. J. C. Solomon, Los Angeles; Dr. H. C. Hervey, San Jose; Dr. H. Scott Turner, Pomona, and Dr. G. W. Stout, Ukiah.

DR. J. A. MUNK, President.

To the members of the Eclectic Medical Society of the State of California:

The next meeting of this Society will be held in San Francisco, April 27-28-29, 1909. Important business must be transacted at that meeting; all Eclectics are vitally interested. The grand and noble principles of Eclecticism still remain. The continuance of the privilege of free thought and action in medicine depends largely upon those who show their loyalty by their attendance and support.

Our organization must be perfected, and with the present attitude of the National Association, such a unanimity of action is about to be realized. It is important that all should realize the necessity for a closer alliance, affecting as it does the status of American medicine.

Your attendance and co-operation is not only urged, but expected.

J. A. MUNK, President.

J. PARK DOUGALL, M.D., Secretary.

LOS ANGELES ECLECTIC MEDICAL SOCIETY.

The regular monthly meeting of the Los Angeles County Eclectic Medical Society was held on Monday, September 1st, at 8:00 p.m. at the offices of Drs. Welbourn, Security Building.

Dr. M. Blanche Bolton read a paper on Intestinal Obstruction.

A number of interesting clinical reports were made by different members.

The next meeting will be on October 6th, at the same place at which time Dr. Conrad will read a paper and Dr. Turner will report a clinical case.

Adjournment.

P. M. Welbourn, Secretary, M. B. Bolton, President.

NEWS ITEMS.

Dr. W. L. Jerman, formerly of Long Beach has changed his address to La Canada, Cal.

Mrs. A. B. Simmons, wife of Dr. Simmons of Chino has been visiting in Long Beach for a few weeks.

Dr. A. O. Conrad, Tropico, has returned from his vacation which he spent at Ocean Park.

Dr. B. Roswell Hubbard will take his vacation during the coming month hunting quail.

The college opened on schedule time, Monday, September 14th, and everyone was in his proper place at the appointed time.

Germain Ray who has been the guest of Doctor Perce of Long Beach for the summer, has returned to his home in Youngstown, Ohio.

Dr. L. A. Perce and Dr. E. R. Harvey are planning to join an automobile party on a quail hunting trip as soon as the hunting season opens.

There was a called meeting of the trustees of the College on Sept. 14, which was to consider important matters in regard to the College welfare.

Dr. Jennie M. Covert, Chicago, who has spent the past year in Los Angeles has returned to her home. Dr. Covert presented to the College a full set of metallic splints for fractures of infants.

Dr. A. P. Baird has returned from a fishing trip in San Gabriel Canyon and at Redondo. Dr. Baird has moved his office from the Auditorium Building to the International Bank Building.

There were meetings of the College faculty on the second and fourth Tuesdays in September, but during October there will be but one meeting which will be held on the third Tuesday, Oct. 20.

The September meeting of the Los Angeles County Eclectic Medical Society was well attended. The October meeting will be on Oct. 6, at the offices of Drs. Welbourn, at which time Dr. Conrad will read a paper.

Dr. F. N. Folsom, Forestville, Cal., writes that he desires to change to a location in a city and would like to dispose of his practice to an Eclectic. He is located in a prosperous fruit-raising district, and is the only physician within eight miles. Income $3,000 to $4,000 yearly. Terms easy.

Henry M. Owens, has moved his office from 710 Fillmore Street to 410-411-412 Mechanics Savings Bank Building, San Francisco. Mr. Owens was Professor of Medical Jurisprudence in the California Eclectic Medical College when the College was located in San Francisco.

We would like to call the attention of every Eclectic physician in the state to this matter of Medical Legislation. It is time that every one should wake up and get busy. The committee on legislation will take the lead, but every one must help if they are to accomplish anything.

Dr. Peterson was severely burned and nearly lost his large touring car a day or two ago. In making a professional trip near Santa Ynez, while traveling at a high rate of speed flames shot from beneath the body of the car. On investigation he found the drive chain had gathered straw from the roads, which sparks from the engine had ignited. Dr. Peterson succeeded in putting out the fire, but his hands and arms were seared.—Ex.

Sacramento, Sept. 12.—There will be no investigation by Governor Gillett of the charges made at the recent examination of the State Board of Medical Examiners that partiality was shown students from the Cooper Medical college by the members of the Board.

Charles L. Tisdale, secretary of the Board, was in consultation with the governor this morning, and at the conclusion of the conference it was announced that the executive was satisfied the accusations had no foundation—*L. A. Express.*

THE FIRST SYMPTOMS OF MIGRAINE.

Dr. J. J. Caldwell of Baltimore, Md., in "Medical Progress" writes as follows: "The treatment of migraine, to be correct, must be adjusted on the basis of the element of causation. Constipation, if present, should be treated by a proper dietary and regular habits, but purgatives should be avoided. Only mild laxatives should be employed, and they should be abandoned when diet regulates the bowels, as proper diet will do. During the premonitory stage we can generally abort or rather prevent the development of an attack by the administration of two antikamnia tablets. They should be given as soon as the first symptoms of the attack are manifest. If then, all symptoms are not speedily dissipated, another dose should be given in three-quarters of an hour or an hour. This means is a most effectual one to abort an attack, and when the attack is developed, antikamnia tablets will relieve the pain usually in about forty minutes."

After using a mydriatic in an adult, instil pilocarpin 1%, and keep the patient under observation until the pupil contracts. —*American Journal of Surgery.*

Yellow salve soon turns brown on exposure to light, if made with lard as a base. Cold cream or lanolin makes a good base. Keep in a porcelain jar with a screw top.—*American Journal of Surgery.*

After using cocain solution on the eye, be sure to keep it well irrigated, or protected by a bland ointment, or bandaged, to prevent drying and subsequent erosion.—*American Journal of Surgery.*

Strong antiseptic solutions should be avoided in dressing scalp wounds. For "wet dressings" Thiersch's (boro-salicylic) or Burow's (aluminum acetat) solution is sufficiently antiseptic.—American Journal of Surgery.

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